LEGISLATIVE SERVICES AGENCY
OFFICE OF FISCAL AND MANAGEMENT ANALYSIS

301 State House
(317) 232-9855

FISCAL IMPACT STATEMENT

LS 7409 **NOTE PREPARED:** Apr 28, 2003
BILL NUMBER: SB 493 **BILL AMENDED:** Apr 24, 2003

SUBJECT: Home- and Community-Based Services.

FIRST AUTHOR: Sen. Server **BILL STATUS:** Enrolled
FIRST SPONSOR: Rep. C. Brown

FUNDS AFFECTED: X **GENERAL** **IMPACT:** State
DEDICATED
X **FEDERAL**

Summary of Legislation: This bill establishes a caretaker support program. It encourages the Indiana Health Facility Financing Authority to work with for-profit health facilities that are partnered with nonprofit agencies in converting licensed beds to less intensive care beds through bonds. The bill requires the Office of the Secretary of Family and Social Services to establish a home- and community-based long-term care service program and establishes eligibility for the program. The bill requires the Office of Medicaid Policy and Planning (OMPP) to apply for: (1) a waiver to amend the Aged and Disabled Waiver to include any service offered by the Community and Home Options to Institutional Care for the Elderly and Disabled (CHOICE) program; and (2) a waiver to amend Medicaid waivers to include spousal impoverishment protection provisions that are at least at the level of those offered to health facility residents. The bill specifies protections an individual receiving Medicaid waiver services must have.

Effective Date: Upon passage; July 1, 2003.

Explanation of State Expenditures: *Summary:* This bill requires several significant changes in the provision of long-term care services in the state. The bill contains provisions that may result in cost savings in both the short and the long term. The ultimate cost of this bill will be dependent upon legislative and administrative actions.

The bill establishes a Caretaker Support Program to be administered by the Division of Disability, Aging, and Rehabilitative Services (DDARS). This requirement potentially has a fiscal impact associated with program administration only. No services are required to be provided, and no state funds are appropriated. *(See background information below.)*

The bill also requires the services available under the Medicaid waiver to be equivalent to the services available in the CHOICE program. The fiscal impact of this provision would be dependent upon

administrative actions. *(See background information below.)*

The bill requires the addition of adult foster care services to the list of services available as home- and community-based options within the comprehensive program to be established by FSSA. The fiscal impact of this provision will be dependent upon administrative actions taken to implement this service. The description of the service, definition of qualified providers, proposed reimbursement and client eligibility are unknown factors. *(See the background information below.)*

The bill requires the Office of Medicaid Policy and Planning to amend three Medicaid waivers to increase the income eligibility standards to 300% of the Supplemental Security Income (SSI) level. (The other waivers have already been amended to include this eligibility standard.) A preliminary fiscal estimate of the total cost of this provision indicates the total maximum cost could be $3.2 M, or $1.2 M in state funds in the Aged and Disabled Waiver only. However, changing this income standard would potentially allow for an increase in savings associated with home- and community-based waiver diversion slots. This provision could be cost neutral, provide program savings, or provide savings as long as the number of waiver slots are controlled. *(See background information below.)*

The bill requires OMPP to amend Medicaid waivers to include spousal impoverishment protection. This provision has a minor administrative impact that should be absorbable within the current level of resources available to the Division of Disability, Aging, and Rehabilitative Services (DDARS) as long as the number of funded waiver slots are controlled. *(See the background discussion below.)*

The bill requires the Division to implement self-directed care within the Medicaid waivers and the CHOICE program. Self-directed care should be a fiscally neutral option. In addition, DDARS reports that self-directed attendant care is now an available option in all the waivers that include attendant care. The Division reports that implementation of this alternative is imminent in the Aged and Disabled waiver.

BACKGROUND:

Caretaker Support Program Background: The provisions regarding the Caretaker Support Program establish a program within the Division of Disability, Aging, and Rehabilitative Services (DDARS) similar to the National Family Caregiver Support Program. The national program was added as an amendment to the Older Americans Act in 2000 providing an opportunity for the aging network to develop a service delivery system to respond to the needs of caretakers. Indiana received a federal grant allocation of $2.3 M that was released in February of 2001. These funds require a 25% non-federal share that must be provided from state or local sources. The match may be met with cash or in-kind expenditures. The Area Agencies on Aging (AAA) report that the match is provided by the AAAs. The federal requirements for services that must be included in a state program include the following:

(1) information to caregivers about available services;
(2) assistance to caregivers in gaining access to the services;
(3) individual counseling, organization of support groups, and training for caregivers to assist them in making decisions and solving problems related to their caregiving roles;
(4) respite care to enable caregivers to be temporarily relieved from their responsibilities; and
(5) supplemental services, on a limited basis, to complement the care provided by the caregiver.

The federal program has provisions allowing the state agency to use 5% of the total grant or $500,000 to pay for not more than 75% of the cost of administration of the State Plan required for the funding. Five percent

of the 2001 state allotment of $2.3 M was $116,580, requiring a state match of $38,860. Since the Area Agencies on Aging (AAA) received the grant funding, it appears that DDARS was able to establish the state plan and the grant program within the level of administrative resources available. This provision does not require the state to provide additional services, nor does it appropriate funds.

Medicaid Waiver Services Equal to CHOICE Background: This bill requires that OMPP amend the Medicaid Aged and Disabled (A & D) waiver to include any service that is offered under the CHOICE program. The bill further specifies that a service under the waiver may not be more restrictive than the corresponding service provided in the CHOICE program. DDARS staff reports that the list of services that are provided under the waiver and under CHOICE are essentially the same. The difference between the program services vary mainly in rates and providers. CHOICE is a locally controlled program: the local Area Agency on Aging determines the providers, negotiates a local rate, and pays that rate. Rates for Medicaid waiver services are set on a statewide basis, and the providers must meet Medicaid program standards. Waiver services are paid and processed through the Medicaid system. This provision may or may not have an impact on the cost of the Medicaid Waiver program or the CHOICE program depending upon how specific services are impacted by this standardization provision. First, there appears to be no prohibition from the Secretary revising the CHOICE program to mirror the Medicaid waiver provisions. Second, waiver recipients may receive the same services, but the amount, duration, or the scope of services may vary for different reasons depending upon the specific service provided and whether it is a waiver service or provided as a Medicaid State Plan service.

Adult Foster Care Services Background: The bill adds adult foster care to the list of services that are available as a community and home care service option in the comprehensive home care program required by the bill. DDARS has requested an amendment to the Developmentally Disabled Medicaid waiver that adds this service, so administrative actions necessary to define the service and eligible providers may be in process. Numbers of eligible individuals, availability of qualified providers, and reimbursement rates are unknown.

300% of the SSI-Level Income Eligibility Standards Increase Background: Similar to the spousal impoverishment protection issue, the monthly income eligibility standard available for home-based waiver services is much lower than the standard available for persons who choose to be admitted to a nursing facility. Under the Medicaid Aged and Disabled waiver, an eligible individual may have no more than the monthly SSI amount of $545. This means that if the individual's income exceeds the $545 in any month, the individual must "spend down" the income before they qualify for services that month. In contrast, the same individual can be eligible for nursing home care by paying all of their income, up to $1,635 (300% of the SSI level) less $52 allowed for a personal needs allowance, to the nursing facility. Raising the waiver income eligibility standard to the same 300% SSI level as is available for nursing home care would allow individuals to remain in their homes, maintain more income, and receive services that are generally less costly than those that would be incurred in a nursing facility. A preliminary fiscal estimate of the total cost of this provision indicates the total maximum cost could be $3.2 M, or $1.2 M in state funds in the Aged and Disabled waiver only. The fiscal impact is associated with the elimination of the "spend down" requirement for existing waiver-eligible individuals. The fiscal impact attributable to the Traumatic Brain Injury waiver and the Assisted Living waiver is not known at this time.

Changing the income eligibility standard would potentially allow for an increase in savings associated with home- and community-based waiver diversion slots. OMPP has applied for and been approved to add 1,000 priority waiver slots for individuals who are discharged from a hospital to a nursing facility. OMPP has identified this population as a priority for achieving savings by delaying nursing home admission. Often, frail elderly individuals are discharged from a hospital stay to recuperate in a nursing facility. Once in a facility,

OMPP has observed that they tend to stay there. With priority waiver slots and equal financial eligibility standards, this population could be targeted to receive in-home services upon return to the individual's home; potential savings would occur immediately. This provision could be cost neutral, provide program savings, or provide savings as long as the number of funded waiver slots are controlled. An additional effect of the bill would be to increase the number of individuals eligible for Medicaid waiver in-home services; increasing the waiting list for services. DDARS reports the current waiting list for the Aged and Disabled waiver to be 493 individuals; there were 5 persons on the Assisted Living waiver waiting list, and the Traumatic Brain Injury waiver waiting list had 83 individuals. Advocates have reported that 70% or more of the current CHOICE recipients could qualify for Medicaid waivers at the 300% income standard. The waiting list could grow by thousands if this is true. There are currently 12,500 individuals receiving CHOICE services, 70% would add 8,750 additional persons to waiver waiting lists.

Spousal Impoverishment Asset Protection Background: The bill requires the Division to amend the Medicaid waivers to include asset protection provisions for married couples referred to as spousal impoverishment. Currently, the institutionalization of one spouse, leaving the other to continue to reside in the community, triggers expanded asset protections for the community spouse when determining the Medicaid eligibility of the institutionalized spouse. The community spouse is allowed to keep up to about $89,000 in assets; more than would otherwise be permitted under the Medicaid rules. (Couples who would prefer to receive services in their own home are currently allowed to keep assets totaling $2,250.) This bill would allow the application of the same spousal impoverishment rules for Medicaid eligibility for in-home waiver services as are applicable for institutional care. In November 2002, DDARS submitted a request to amend the Aged and Disabled waiver to include the spousal impoverishment provisions to the Centers for Medicare and Medicaid Services (CMS). This amendment request is still awaiting CMS approval. The bill would require that DDARS request similar amendments for the Traumatic Brain Injury waiver and the Assisted Living waiver. If the level of funded waiver slots is controlled, this provision would have a minor administrative impact that should be absorbable within the current level of resources available to DDARS. An additional effect of this provision would be to increase the number of individuals eligible for Medicaid waiver in-home services; increasing the waiting list for services. Currently, DDARS reports 493 individuals on the Aged and Disabled waiver waiting list for services.

OMPP reports the total FY 2002 preliminary annual Medicaid cost for Aged and Disabled waiver recipients was $19,880 per recipient; average home-based services per recipient were $7,583, and the annual cost for state plan costs for waiver recipients was $12,297. Comparable total institutional costs for the Aged and Disabled waiver are identified as $25,863 per recipient; average institutional cost per recipient was $20,727, and the annual cost for State Plan services for institutional recipients was $5,136.

The Governor's Commission on Home- and Community-Based Services and OMPP are engaged in a detailed examination of the issues regarding the equalization of the financial incentives for long-term care services offered under the Medicaid program. A comprehensive fiscal analysis is targeted to be completed by the end of February 2003.

Expenditures in the Medicaid program are shared, with approximately 62% of program expenditures reimbursed by the federal government and 38% provided by the state.

Explanation of State Revenues: See *Explanation of State Expenditures* regarding federal reimbursement in the Medicaid program.

Explanation of Local Expenditures:

Explanation of Local Revenues:

State Agencies Affected: Family and Social Services Administration, Office of Medicaid Policy and Planning, and the Division of Disability, Aging, and Rehabilitative Services.

Local Agencies Affected: Area Agencies on Aging.

Information Sources: Amy Kruzan, Legislative Liaison for the Family and Social Services Administration, (317)-232-1149; "Adults with Severe Disabilities, Federal and State Approaches for Personal Care and Other Services", U.S. General Accounting Office, May 1999 (GAO/HEHS-99-101); "Understanding Medicaid Home and Community Services: A Primer", U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, May 2000; Administration on Aging Program Instructions, at www.aoa.gov/pi/pi-01-02.html ; Governor's Commission of Home and Community-Based Services, Interim Report, December 23, 2002.

Fiscal Analyst: Kathy Norris, 317-234-1360